**IN THE UNITED STATES DISTRICT COURT**
**FOR THE WESTERN DISTRICT OF VIRGINIA**
**ABINGDON DIVISION**

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| **GAYLENE KING, ETC.** | ) | |
| | ) | |
| Plaintiff, | ) | Case No. 1:00CV00004 |
| | ) | |
| v. | ) | **OPINION** |
| | ) | |
| **CONSOLIDATION COAL COMPANY,** | ) | By: James P. Jones |
| | ) | United States District Judge |
| Defendant. | ) | |

In this ERISA case, I find that the decision of the benefit plan administrator denying the plaintiff's claim for life insurance benefits is supported by substantial evidence and cannot be overturned.

I

The plaintiff, Gaylene King, is the widow of Johnnie R. King and the administratrix of his estate. Mr. King was employed as a coal miner by the defendant Consolidation Coal Company ("Consol") beginning in 1981. Under the Benefit Plan for UMWA Represented Employees of Consolidation Coal Company ("the Plan"),[1] Mr. King was insured by a $50,000 life insurance policy from Trans-General Life

[1] The Plan is an employee benefit plan within the meaning of the Employment Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C.A. § 1001-1461 (West 1999 & Supp. 2000).

Insurance Company. Mrs. King was the named primary beneficiary of the life insurance policy.

In early 1994, Mr. King was diagnosed with throat and lung cancer. He took disability leave from work from February 23, 1994, through June 8, 1994. During this time, he received sickness and accident ("S&A") benefits under the Plan. Except for a brief return to work for two days in June 1994, Mr. King was never able to return to his employment at Consol. In December 1994, Mr. King's S&A benefits expired, as well as his dental plan coverage.

Mr. King's life insurance and medical plan coverage terminated on June 30, 1995. Pursuant to federal law,[2] a notice was sent by Consol to Mr. King informing him of the termination of medical plan coverage and providing him with the option of continuing medical plan coverage by assuming private payment of the premiums. Mr. King opted to continue the medical plan by making monthly premium payments, which were paid until his death.

The COBRA notice did not inform King of the termination of his life insurance policy.[3] In an affidavit filed with this court, Mrs. King alleges that after receiving the

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[2] *See* Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), Pub. L. No. 99-272, tit. X, 100 Stat. 82 (1986).

[3] COBRA only requires notice regarding an employee's "group health plan." *See id*. The plaintiff does not claim that Consol's failure to include notice of the termination of the life insurance policy constituted a violation of COBRA.

COBRA notice regarding health insurance, she called Consol to inquire about the life insurance policy, and was informed that she would receive a "31-day notice if the life insurance benefits were affected by Mr. King's medical leave." (King Aff. ¶ 7.) Mrs. King further states that neither she nor Mr. King ever received "any notice of any kind regarding life insurance." (King Aff. ¶ 10.)

Mr. King died on April 6, 1996. Although he had not worked since June 1994, Mr. King's name appeared on a list of hourly employees intended to be laid off effective April 8, 1996.[4] On the form listing each employee targeted for layoff, the space labeled "Date Last Worked" for Mr. King is blank. The spaces labeled "Medical Expiration" and "Dental Expiration," are marked "N/A." Similarly, in a document prepared to notify Mr. King of his layoff, form language beginning, "Medical Plan will terminate effective," is completed with the handwritten notation, "N/A."

The Plan's Summary Plan Description provides a "Conversion Privilege" for life insurance, allowing an employee "[u]pon application to the insurance carrier within 31 days after life insurance coverage terminates, . . . [to] arrange to continue life insurance protection under an individual policy." (Summ. Plan Desc. at 65-66.)[5] It is undisputed

[4] Consol was apparently unaware of Mr. King's recent death.

[5] A copy of the Summary Plan Description was submitted to the court by the defendant, along with a copy of Mr. King's personnel file and the Plan's claim file. The plaintiff does not dispute the authenticity of these documents.

that neither Mr. nor Mrs. King attempted to obtain an individual policy under the conversion privilege. Therefore, after Mr. King's death on April 6, 1996, Mrs. King did not receive life insurance benefits under the Plan, because the policy had terminated on June 30, 1995. In a letter dated June 23, 1999, the Plan administrator denied Mrs. King's claim to the life insurance benefits, reasoning that due to Mr. King's inability to work and without the exercise of the conversion privilege, the life insurance policy had properly terminated under the Plan.

On November 19, 1999, Mrs. King filed suit individually and as administratrix of her husband's estate against Consol in the Circuit Court of Tazewell County, Virginia. The case was timely removed to this court on January 6, 2000.[6] The parties have filed cross motions for summary judgment and briefed and argued the issues. The case is now ripe for decision.

II

It is undisputed that the Plan grants its administrator the discretion to determine benefit eligibility. (*See* Summ. Plan Desc. at 1-2, 73-74.) Accordingly, under ERISA,

[6] The case was removed pursuant to 28 U.S.C.A. § 1441(b) (2000).

a reviewing court must apply a deferential standard of review, in which the fiduciary's decision will not be disturbed if reasonable, even if the court would have come to a different conclusion. *See Ellis v. Metropolitan Life Ins. Co.*, 126 F.3d 228, 232 (4th Cir. 1997). In determining the reasonableness of a fiduciary's discretionary decision, the court may consider, *inter alia*, the following factors:

> (1) the language of the plan; (2) the purposes and goals of the plan; (3) the adequacy of the materials considered to make the decision and the degree to which they support it; (4) whether the fiduciary's interpretation was consistent with other provisions in the plan and with earlier interpretations of the plan; (5) whether the decisionmaking process was reasoned and principled; (6) whether the decision was consistent with the procedural and substantive requirements of ERISA; (7) any external standard relevant to the exercise of discretion; and (8) the fiduciary's motives and any conflict of interest it may have.

*Booth v. Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan*, 201 F.3d 335, 342-43 (4th Cir. 2000).

If the fiduciary has a financial interest itself in the payment of claims, the reviewing court must modify the abuse of discretion standard "according to a sliding scale." *Id.* at 233. By virtue of this modification, "[t]he more incentive for the administrator or fiduciary to benefit itself by a certain interpretation of benefit eligibility or other plan terms, the more objectively reasonable the administrator or fiduciary's decision must be and the more substantial the evidence must be to support it." *Id.*

Where, as here, there is a potential conflict of interest because the employer (or an executive of the employer) is also the plan administrator or fiduciary, it is appropriate to apply this modified abuse of discretion standard. *See Hickey v. Digital Equipment Corp.*, 43 F.3d 941, 946 (4th Cir. 1995).

Under this standard of review, I find that the Plan administrator did not abuse his discretion in refusing to grant Mrs. King life insurance benefits under the Plan.

III

A

The plaintiff's principal argument is that the Plan administrator abused his discretion in denying life insurance benefits because Mr. King was an "active employee" at the time of his death, and therefore was entitled to life insurance coverage. I find that the administrator's interpretation of the Plan is supported by substantial evidence.

The Plan grants benefits to "active employees." (Summ. Plan Desc. at 19.) However, the terms of the Summary Plan Description defining "active employee" are not precise. The plan first defines "active employee," in pertinent part, as "any Employee who [] is actively at work for the Employer on the Effective Date of the Wage Agreement." (*Id.*) The effective date of the wage agreement is further identified

as February 1, 1993. (*Id.*) The plaintiff argues that because Mr. King was actively working on February 1, 1993, he should have been considered an active employee at the time of his death on April 6, 1996. Under the plaintiff's reasoning, however, any employee who worked on February 1, 1993, would be considered an active employee in perpetuity, regardless of subsequent changes in employment status. The Plan administrator did not abuse his discretion in declining to follow such a rationale.

The Plan also defines an "active employee" as one having "active employment with the Employer." (*Id.*) "Active employment" is not defined. The plaintiff argues that Mr. King, notwithstanding his disabled status, still fell within the meaning of "active employment" under the Plan.

In support of her argument that Mr. King was an active employee when he died, the plaintiff directs the court's attention to *Tester v. Reliance Standard Life Insurance Co.*, 228 F.3d 372 (4th Cir. 2000). In that case, the appellant successfully argued that an employee's benefits were wrongfully terminated because the employee was still an "active employee" under the benefit plan when she died. *See id.* at 377. As in this case, the plan did not clearly define the term "active employee," and the Fourth Circuit held that "where a term is ambiguous, we must construe it against the drafter, and in accordance with the reasonable expectations of the insured." *Id.* Under the facts of *Tester*, the court held that the employee "was working . . . on a regular basis and that

she was simply out sick when she died." Therefore, the plan administrator's denial of benefits was improper. *Id.*

This case is distinguishable from *Tester*. Following *Tester*'s mandate to interpret ambiguous terms in the Plan in accordance with traditional common law principles, I cannot find that the Plan administrator abused his discretion in his determination that Mr. King was not an active employee at the time of his death. Unlike the plaintiff in *Tester*, who had been on medical leave for approximately five weeks prior to her unexpected death, Mr. King had not worked for more than two years when he died.

Furthermore, the express terms of the Summary Plan Description provide for the termination of benefits when an employee ceases to actively work. The benefits termination schedule is based on the number of hours an employee worked in the twenty-four months prior to the date the employee last worked. (*See* Summ. Plan Desc. at 62.) The Plan provides that "in no event shall . . . continuation of coverage [last] beyond the balance of the month plus 12 months from the date last worked." (*Id.* at 64.) Mr. King's medical and life insurance benefits were in fact terminated on June 30, 1995, twelve months after he last worked on June 9, 1994. Thus, the Summary Plan Description provided notice to the Kings that Mr. King was no longer entitled to full benefits as an active employee, and the Plan administrator's denial of benefits was "in

accordance with the reasonable expectations of the insured," as required by *Tester*. *See* 228 F.3d at 377.

That Mr. King's name appeared on a list of employees to be laid off around the time of his death does not prove that he was an active employee deserving of benefits under the Plan. As discussed above, the Summary Plan Description clearly provided a schedule for the termination of benefits when an employee ceases working. The documents regarding Mr. King's lay off indicate that he had no medical or dental coverage at that time; all references to insurance coverage in those documents are marked "not applicable." Finally, even if the documents did indicate that Mr. King was entitled to benefits, they could not serve to alter the written language of the Plan. *See HealthSouth Rehab. Hosp. v. Am. Nat'l Red Cross*, 101 F.3d 1005, 1010 (4th Cir. 1996) ("ERISA simply does not recognize the validity of oral or non-conforming written modifications to ERISA plans.").

Not only is the Plan administrator's decision supported by the language of the Plan, but it is also consistent with prior interpretations of the Plan. An affidavit of a Consol representative cites several prior decisions of the Plan's trustees, sitting in review of decisions of the Plan administrator. (*See* Shaffer Aff. ¶ 7.) Of these decisions, ROD No. 88-674, is most on point. (*See* Shaffer Aff. Ex. C.) In that case, dated June 23, 1995, a disabled employee died after his health and life insurance

benefits had duly expired twelve months after his last day of work. (*See id.*) The employee's widow argued that although Consol provided a COBRA notification of the termination of health benefits, they had not been informed of the termination of life insurance coverage. (*See id.*) The trustees upheld the Plan administrator's denial of life insurance benefits to the widow, reasoning that the failure to notify the employee of life insurance termination did not alter the clear language of the Plan setting forth the schedule for benefits termination. (*See id.*)

Therefore, because Mr. King's life insurance coverage was terminated in accordance with the provisions of the Plan, and was consistent with prior interpretations of the Plan, the administrator's decision to deny benefits was supported by substantial evidence.

B

In support of her motion for summary judgment, the plaintiff submitted an affidavit in which Mrs. King states that she asked Consol about the termination of the life insurance policy and was told that she would receive a notice at least thirty-one days before the policy would terminate. Mrs. King contends that she never received

such a notice, and that had she received notice of termination from Consol, she "would have done whatever was necessary to keep the policy in effect until Mr. King's death." (King Aff. ¶ 11.) While not argued as such, these statements of Mrs. King set forth the elements of a claim for promissory estoppel, whereby a party is liable where that party makes a promise, induces reasonable detrimental reliance by the plaintiff, then fails to keep the promise. *See Heckler v. Community Health Servs. of Crawford County, Inc.*, 467 U.S. 51, 59 (1984) (quoting Restatement (Second) of Torts § 894(1) (1979)).

In this case, however, promissory estoppel is unavailing. The Fourth Circuit has squarely rejected the application of estoppel to ERISA claims such as asserted here. *See, e.g., Bakery & Confectionery Union & Indus. Int'l Pension Fund v. Ralph's Grocery Co.*, 118 F.3d 1018, 1027 (4th Cir. 1997) ("In this circuit, equitable estoppel is not available to modify the written terms of an ERISA plan in the context of a participant's suit for benefits."); *HealthSouth Rehab. Hosp. v. Am. Nat'l Red Cross*, 101 F.3d at 1010 ("We have never recognized estoppel arguments which would serve to vary the terms of a written plan.").

The facts of this case are similar to those of *Coleman v. Nationwide Life Insurance Co.*, 969 F.2d 54 (4th Cir. 1992). In *Coleman*, medical insurance coverage for an employee's family was terminated in accordance with the written provisions of an employee benefit plan. *See id.* at 56. Before entering the hospital for the birth of

her baby, the employee's wife received several incorrect oral assurances over the telephone that her medical expenses would be covered by the plan. *See id.* at 56-57. After Mrs. Coleman incurred medical expenses, the insurance company denied benefits. *See id.* at 57. The court rejected the plaintiff's estoppel claims, stating that "[e]quitable estoppel principles, whether denominated as state or federal common law, have not been permitted to vary the written terms of a plan." *Id.* at 59.

Like the plaintiff in *Coleman*, Mrs. King argues that because the defendant allegedly made an erroneous oral representation, inconsistent with the plan language, Consol should be held liable for breaking its word. In light of circuit precedent rejecting estoppel claims in ERISA cases, however, I cannot accept the plaintiff's position.

C

Finally, at oral argument, although not in her motion for summary judgment, the plaintiff raised the issue of breach of fiduciary duty. Because the plaintiff's fiduciary duty claim in this case is in fact a typical ERISA claim of wrongful denial of benefits by the Plan administrator, I must reject this argument.

It is correct that "ERISA administrators have a fiduciary obligation 'not to misinform employees through material misrepresentations and incomplete, inconsistent or contradictory disclosures.'" *Griggs v. E.I. DuPont de Nemours & Co.*, Nos. 99-2508, 99-2607, 2001 WL 20518, at *8 (4th Cir. Jan. 9, 2001) (quoting *Harte v. Bethlehem Steel Corp.*, 214 F.3d 446, 452 (3d Cir. 2000)). However, the Fourth Circuit has refused to recognize a separate fiduciary duty claim where the claim is based on "a plan administrator's denial of benefits or an action by the defendant closely related to the plaintiff's claim for benefits, such as withholding of information regarding the status of benefits." *Smith v. Sydnor*, 184 F.3d 356, 362 (4th Cir. 1999), *cert. denied*, 528 U.S. 1116 (2000). Here, the basis of Mrs. King's claim for breach of fiduciary duty is Consol's failure to notify the Kings of the termination of the life insurance policy. *Smith* makes it clear that such "withholding of information regarding the status of benefits" does not merit a separate claim for breach of fiduciary duty, but rather falls under the plaintiff's ERISA claim in general. *Id.*

IV

For the foregoing reasons, summary judgment will be granted in favor of the defendant.

ENTER: January 25, 2001

United States District Judge